GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF MOTOR VEHICLES

MEDICAL/EYE REPORT

You may mail or fax this form to DC DMV Medical Review Services, PO Box 90120, Washington, DC 20090 or fax to (202) 727-0463.
For additional information visit our website: www.dmv.dc.gov or call our Customer Service Call Center at 202-727-5000.

This section to be completed by customer:

First Name	Middle Name	Last Name

Street	Apt #	City	State	Zip Code
		Washington	DC	

Date of Birth (MM/DD/YYYY)	Driver's License Number	Expiration Date	E-Mail Address (Optional)

MEDICAL REPORT: This section must be completed by a licensed physician

Alzheimer	*Diabetes	Seizure or Fainting Spells	Other Mental or Physical Conditions
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Medical Report section must be completed by physician **and Eye Report section must be completed by* Ophthalmologist or Optometrist

Seizure or fainting spells	If applicant has a mental or physical condition that would impair his/her ability to drive, please indicate condition:
If yes, when was the last episode? _____ **NOTE: *Must be seizure free for twelve (12) consecutive months, unless single episode, night time only seizures or due to medication adjustments***	

Indicate any medical restrictions required?

Indicate by checking one (1) of the following when the condition should be rechecked by a physician
Seizure disorders require a one year physician examination for five (5) consecutive years

☐ Six (6) months	☐ One (1) year	☐ Two (2) years	☐ Three (3) years	☐ Four (4) years

Based on your medical diagnosis, does the applicant have the ability to safely operate a motor vehicle? Yes ☐ No ☐

Physician Information:

Physician License Identification Number and State:_____ Telephone No:_____

Physician Address: _____

Physician Signature:_____Date:_____

EYE REPORT: This section must be completed by a licensed Ophthalmologist or Optometrist

Diabetes	Glaucoma	Cataracts	☐ Other Eye Disease:	Failed DMV Vision Test
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	_____	☐ Yes ☐ No

Vision without Glasses	Vision with Glasses	Field of Vision in horizontal meridian	Indicate by checking one (1) of the following when the condition should be rechecked.
Right Eye 20/_____ Left Eye 20/_____ Both Eyes 20/_____	Right Eye 20/_____ Left Eye 20/_____ Both Eyes 20/_____		☐ Six (6) months ☐ Two (2) years ☐ One (1) year ☐ Three (3) years ☐ Four (4) years ☐ **N/A**
Minimum Vision Requirements (with or without corrective lenses). No less than 20/40 in the best eye OR no less than 20/70 in the best eye and field of vision at least 140 degrees.			Indicate any vision restrictions required?

Based on your medical diagnosis, does the applicant have the ability to safely operate a motor vehicle? Yes ☐ No ☐

Ophthalmologist or Optometrist Information:

Physician License Identification Number and State:_____ Telephone No: _____

Physician Address: _____

Physician Signature:_____Date:_____

The making of a false statement on this form is a violation of DC law and is subject to a fine of up to $1,000 or 180 days imprisonment of both (D.C. Official Code §22-2405).
To report waste, fraud or abuse by any DC Government official or agency, call the DC Inspector General at 1-800-521-1639.